

inspection like a little bolus being swallowed. It is thus forced into the bladder in intermittent jets.—*Annals of Gynaecology and Paediatrics*, May, 1893.

TUMORS.

Treatment of Nævi by Sublimate Collodion. By Dr. CÆSFELD (Barmen, Austria). The writer recommends sublimate collodion (1 : 8) in the treatment of vascular nævi. It acts with certainty, is painless and rapid. No disagreeable side action has been observed. The procedure is as follows: A moderately thick coating is applied over the nævus and 1–2 mm. over on to the surrounding skin. Then blow on the collodion in order to aid its drying, and repeat the procedure once or twice, according to the size. Be careful to see that the patient's friends are cautioned about protecting this coating from any injury, as in washing. In ten to twelve days this falls off and leaves a dry, white, superficial and smooth cicatrix. In case a few groups of vessels remain in the scar, repeat it again until it has completely disappeared. This method is also applicable in larger teleangiectases.—*Ärztlicher Praktiker*, No. 13, 1893.

BONES, JOINTS, ORTHOPÆDIC.

I. Treatment of Myelogenous Sarcomata of the Long Bones by Resection. By Dr. NEUMANN (Halle). Neumann presented a woman twenty years of age at the twelfth meeting of the German Surgical Society who had fallen down several steps and received a slight injury of the left knee, which fourteen days later had become more painful, with a tendency to collapse at times. The next year she was able to walk only with the aid of a cane. The physician who treated her made an incision below the patella and proposed amputation, which led her to enter the hospital. This incision, which was seven centimetres in length, and crossed by another of five in length, exposed a dirty, gray, immovable mass that proved to be a giant cell

sarcoma. At the opening of the wound the tibia fractured at four fingers' breadth below the joint. After lateral incisions had been made the articulation was opened. The whole upper portion of the tibia was found to be a cancerous mass. Extirpation of all suspected tissue was done, the articular surfaces of the femur and five centimetres of the tibia were sawed off. The remainder of the tibia was cut down to a point and inserted into a corresponding hole which was bored into the condyle of the femur. Suture, drainage and a plaster bandage. In three months the patient was discharged, with a prosthesis. Four months after consolidation was still complete.—*Wiener Medizinische Presse*, No. 18, 1893.

FRANK H. PRITCHARD (Norwalk, Ohio).

II. Hereditary Luxability of the Elbow Joint. By P. A. KELLY, F. R. C. S., Irel. (Barry, Cardiff). A man in youth dislocated his right elbow joint, and in the following year sustained a like injury to the left. These dislocations were not reduced, and for some time he complained of numbness in both hands. The feeling was accentuated in the little finger and half the ring fingers of both hands; apparently the ulnar and musculo-spiral nerves were implicated. He began to waste and the forearms became mere skeletons. Twenty years ago one of his sons dislocated the left elbow, the injury being diagnosed at the time as a fracture, but pulled into place a few months later. Eight years ago another son received a like injury, which was similarly treated and maltreated. The author's patient, a third son, sustained a dislocation at the right elbow joint.—*London Lancet*, February 25, 1893.

JAMES E. PILCHER (U. S. Army).

III. Extirpation of the Ankle for Club Foot.¹ Gulde reports nineteen cases of extirpation of the ankle performed in Bruns' clinic up to the year 1890. Only those cases are reported which have not been lost sight of since the operation. The length of time during which these cases have been observed varies from nine months

¹ Beiträge zur klinischen Chirurgie, Band X, Heft 2, 1893.

to five years. He calls attention to the fact that though many of the operations for club foot give a beautiful cosmetic result, in a short period of time after apparatus and support have been laid aside recurrence of the deformity takes place.

The method of excision of the ankle, as performed by Prof. Bruns, is as follows: The operation is performed under narcosis and by the bloodless method of Esmarch. The skin incision is begun at the tibio-fibular articulation and carried with a slight anterior concavity ten centimetres downward over the prominent talus as far as beneath the medio-tarsal joint, dividing skin, fascia and crucial ligament. The tendons of the extensor digit, longus and brevis are lifted out of their beds and drawn inward. The capsule of the joint is then incised for its entire extent. The capsule with the insertions of the ligaments are separated from the bone, the head and neck of the astragalus are laid bare, and the astragalo-scaphoid ligament divided. The foot is then supinated as far as possible, and the three fasciculi of the external lateral ligament of the ankle joint divided. An elevator is then passed behind the neck of the astragalus, and as the bone is lifted outward its remaining attachments are divided, and it is removed. When there is difficulty in making the articular surfaces of the calcaneus fit into the spaces between the malleoli, a plate of bone may be removed from the inner surface of the external malleolus. The wound is then closed, and over the dressing a plaster bandage is applied. At the end of eight days this is removed in order to take out the sutures; the position of the foot is corrected and put again in a permanent plaster dressing. The after-treatment in plaster is continued for six or eight weeks, and after that the patient is given an ordinary lace shoe with an elevated sole.

The following observations have been made on these cases of Gulde's:

1. *The Position of the Plantar Arch in Walking.*—In eleven of the cases operated upon the patients planted the feet squarely on the ground. The remaining patients walked more on the outer border of the feet, and though not cured of their disease were much im-

proved. These imperfect results are in part due to the improper and often too short a period of after-treatment after leaving the clinic.

2. *The Adduction of the Foot.*—As far as this author has observed the size of the angle of adduction bears no relation to the functional power of the foot.

3. *The Shortening of the Leg.*—This is practically due to the extirpation of the astragalus, though usually it is due, in the paralytic form of clubfoot, to an aphasia of the bones. In many cases, also, the scaphoid bone is elevated until it presses upon the tibia. The shortening which this causes is, however, unimportant.

4. *Observations on the Secondary Mobilization of Lisfranc's Joint.*—The removal of the astragalus usually destroys the function of the ankle joint. Occasionally there is some motion, which remains between the calcaneus and scaphoid, and calcaneus and leg. The movement in Lisfranc's joint in many club feet is even greater than in normal feet. This is especially true in those which have been treated by forcible reduction.

5. *The Hollow Foot.*—Notwithstanding the removal of the astragalus and the tenotomy of the plantar fascia, a degree of hollow foot remains in many cases, quite as pronounced as in the uncorrected foot. Gulde is inclined to think that this is due to the upward extension of the scaphoid bone. Another cause is the shortening of the inner border of the foot.

The results obtained in the nineteen operations performed upon fifteen patients are classified in three groups:

1. Four patients, of whom two underwent double resection of the astragalus, can run and jump the whole day without any pain. The position of the feet is excellent.

2. Five patients can walk for six hours without becoming especially tired, and without causing any especial discomfort in the feet. One of these underwent a double operation. The position of the foot in these cases is good, resting squarely on the floor. The remaining patients step on the outer border of the foot. Angle of adduction, 30° to 40° .

3. The final six cases can walk two or three hours without especial inconvenience. In two of these cases the foot is planted squarely on the ground. The others walk on the outer border of the foot. Angle of adduction, 20° to 45° .

The great feature in all of these cases is that no orthopædic after-treatment had to be carried out. The patients remained in the hospital a few weeks, and at the end of two months were given simple lace shoes.

JAMES P. WAREASSE (Brooklyn).

GYNÆCOLOGICAL.

I. Operative Treatment of Uterine Myo-fibromata.

By H. J. BOLDT, M.D. (New York). In a paper read before the American Gynæcological Society in May, 1893, the author advocates the frequent total extirpation of the fibro-myomatous uterus. His experience with the use of electrolytic efforts in such troubles has not been good; in a number of instances by the use of the galvanic current he has secured the diminution of pain and hæmorrhage; in others not only was the treatment negative in its results, but was even followed by aggravation of the patient's sufferings—twice in his own practice and thrice in the practice of others has he seen the electric current provoke suppuration in the tumors. In submucous and subperitoneal tumors he declares electricity to be useless.

Out of 321 patients afflicted with myoma of the uterus sufficient to produce such symptoms as to compel them to seek advice, in fifty-seven, or $14.45\frac{1}{2}$ per cent., did he advise operation for the removal of the growth. In twenty-one of these total extirpation of the affected organ was done. The author gives the details of these cases. In seven instances the operations were followed by death; from acute mania and from pneumonia and chronic nephritis, in each one case; from shock of operation in three cases; from pre-existing anæmia combined with the shock of operation in two cases. In a number of the cases the operator began from below through the vagina by detaching the vagina from the cervix, separating the bladder from